DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G107	A. BUILDING _____ B. WING _____	01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 06	7129 7TH STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from January 15, 2014 through January 17, 2014. A sample of three clients was selected from a population of six males with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations, interviews and review of client administrative records. Note: The below are abbreviations that may appear throughout the body of this report. Trained Medication Employee - TME Group Home for Individuals with Intellectual Disabilities - GHIID Physician's Order - POS Medication Administration Record - MAR Primary Care Physician - PCP	W 000	Received 4/29/2014 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the TME failed to ensure that each client received medications in accordance with the POS, for one of six clients residing in the facility. (Client #1) The finding includes:	W 368		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

COMPLIANCE SUPERVISOR 2/7/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 368	Continued From page 1 On January 15, 2014, beginning at 8:18 p.m., the TME was observed preparing Client #1's evening medications. At 8:23 p.m., the TME was then observed to administer Depakote, Seroquel and Clonazepam to Client #1. On January 16, 2014, at 9:00 a.m., review of the client's POS and MAR dated January 1, 2014, revealed an order to administer Zyprexa at bedtime. Continued review revealed that the MAR was not signed for the administration of Zyprexa, which indicated that Client #1's Zyprexa was not administered at bedtime. On January 16, 2014, at 3:10 p.m., Client #1's medication bubble packs were observed upon request. The client's Zyprexa remained in the bubble pack, which was dated to be administered on January 15, 2014. During an interview on January 17, 2014, at 10:10 a.m., the TME indicated that Client #1 was sleeping; therefore, he [TME] decided not to administer the Zyprexa to the client. Further interview revealed that he did not inform a nurse or the PCP. At the time of survey, the facility failed to ensure client's received their medications in accordance with their POS.	W 368	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by:	W 369	

W 368

- The facility's Licensed Practical Nurse (LPN) and all Trained Medication Employees (TMEs) have been trained on the guidelines of medication administration. — 02/05/14
- Given the completion of training of all TMEs, the TME who administered medications on 01/17/14, shall be observed three times by the facility's RN to ensure compliance with medication administration standards. — 02/15/14
- The facility's LPN and TMEs have been trained on incident reporting policies and procedures, emphasizing reporting of medication error.
- The facility's Incident Management Coordinator will on a semi-annual basis or as needed train all TMEs and the facility's LPN on incident management policies and procedures with emphasis on reporting medication administration error. — 02/05/14

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W 369	Continued From page 2 Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered without error, for one of the three clients in the sample. (Client #1) The finding includes: On January 15, 2014, beginning at 8:18 p.m., the TME was observed preparing Client #1's evening medications. At 8:23 p.m., the TME was then observed to administer Depakote, Seroquel and Clonazepam to Client #1. On January 16, 2014, at 9:00 a.m., review of the client's POS and MAR dated January 1, 2014, revealed an order to administer Zyprexa at bedtime. Continued review revealed that the MAR was not signed for the administration of Zyprexa, which indicated that Client #1's Zyprexa was not administered at bedtime. On January 16, 2014, at 3:10 p.m., Client #1's medication bubble packs were observed upon request. The client's Zyprexa remained in the bubble pack, which was dated to be administered on January 15, 2014. During an interview on January 17, 2014, at 10:10 a.m., the TME indicated that Client #1 was sleeping; therefore, he [TME] decided not to administer the Zyprexa to the client. Further interview revealed that he did not inform a nurse or the PCP. At the time of survey, the facility failed to ensure client's received their medications in accordance with their POS.	W 369	

W 369

- The facility's Licensed Practical Nurse (LPN) and all Trained Medication Employees (TMEs) have been trained on the **Five Rights of Medication Administration**: Right Individual; Right Medication; Right Dose; Right Time; and Right Route. — **02/05/14**

- The facility's Register Nurse (RN) shall on a quarterly basis train TMEs and the facility's LPN on the guidelines of medications administration — **02/15/14**

-The facility's LPN and TMEs have been trained on incident reporting policies and procedures, emphasizing reporting of medication error. — **02/05/14**

-The facility's Incident Management Coordinator will on a semi-annual basis or as needed train all TMEs and the facility's LPN on incident management policies and procedures with emphasis on reporting medication administration error. — **02/05/14**

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from January 15, 2014 through January 17, 2014. A sample of three residents was selected from a population of six males with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews and review of resident administrative records. Note: The below are abbreviations that may appear throughout the body of this report. Trained Medication Employee - TME Group Home for Individuals with Intellectual Disabilities - GHIID Physician's Order - POS Medication Administration Record - MAR Primary Care Physician - PCP Medication Administration Record - MAR	I 000		
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHIID failed to report all irregularities to the PCP, for one of six Residents residing in the GHIID. (Resident #1) The finding includes: On January 15, 2014, beginning at 8:18 p.m., the TME was observed preparing Resident #1's evening medications. At 8:23 p.m., the TME was	I 473		

Health Regulation & Licensing Administration

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I 473	Continued From page 1 then observed to administer Depakote, Seroquel and Clonazepam to Resident #1. On January 16, 2014, at 9:00 a.m., review of the resident's POS sheets and MAR dated January 1, 2014, revealed an order to administer Zyprexa at bedtime. Continued review revealed that the MAR was not signed for the administration of Zyprexa, which indicated that Resident #1's Zyprexa was not administered at bedtime. On January 16, 2014, at 3:10 p.m., Resident #1's medication bubble packs were observed upon request. The resident's Zyprexa remained in the bubble pack, which was dated to be administered on January 15, 2014. During an interview on January 17, 2014, at 10:10 a.m., the TME indicated that Resident #1 was sleeping; therefore, he [TME] decided not to administer the Zyprexa to the resident. Further interview revealed that he did not inform a nurse or the PCP.	I 473

I 473

- The facility's Licensed Practical Nurse (LPN) and all Trained Medication Employees (TMEs) have been trained on the **Five Rights of Medication Administration**: Right Individual; Right Medication; Right Dose; Right Time; and Right Route. — **02/05/14**

- The facility's Register Nurse (RN) shall on a quarterly basis train TMEs and the facility's LPN on the guidelines of medications administration — **02/15/14**

- The facility's LPN and TMEs have been trained on incident reporting policies and procedures, with emphasis on reporting of medication error. — **02/05/14**

-The facility's Incident Management Coordinator will on a semi-annual basis or as needed train all TMEs and the facility's LPN on incident management policies and procedures, with emphasis on reporting medication error. — **02/05/14**